DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 03		(X3) DATE SURVEY COMPLETED	
		155810	B. WING _		_	R 09/12/2014	
	ROVIDER OR SUPPLIER	DME	,	STREET ADDRESS, CITY, ST 1955 S VERNON ST WABASH, IN 46992	TATE, ZIP CODE	33/12/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	DATE	
{K 000}	INITIAL COMMENTS	3	{K 0	00}			
	Code Recertification conducted on 07/15// Indiana State Depart accordance with 42 C Survey Date: 09/12// Facility Number: 000/ Provider Number: 18/AIM Number: 10027/ Surveyor: Amy Kelle Specialist At this PSR survey, Nome was found in the Requirements for Pa Medicare/Medicaid, 4/Life Safety from Fire National Fire Protectional Fire P	CFR 483.70(a). 14 274 5A014 1660 Ey, Life Safety Code Vernon Manor Children's compliance with riticipation in 42 CFR Subpart 483.70(a), and the 2000 edition of the ion Association (NFPA) 101, C) and 410 IAC 16.2. The e building consisting of arbor, Babbling Brook, s Dream and the Service hall hapter 19, Existing Health of this one story facility was Type II (111) construction and ervice hall and the 300 hall construction and was					
	with smoke detection open to the corridors detectors were provid The facility has a cap	ded in the resident rooms. pacity of 119 and had a					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RF	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03		(X3) DATE SURVEY COMPLETED		
		7 E BOILE	A. BUILDING 01, 03			R	
		155810	B. WING			09/	12/2014
	NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 955 S VERNON ST VABASH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	were sprinklered. A c was used for the stora was not sprinklered. Quality Review by Le	ents have customary access letached storage building age of nursing supplies and x Brashear, Life Safety Code	{K (000}			
{K 000}	Specialist-Medical Su INITIAL COMMENTS A Post Survey Revisi Code Recertification a conducted on 07/15/1 Indiana State Departr accordance with 42 C Survey Date: 09/12/1 Facility Number: 000 Provider Number: 15 AIM Number: 10027 Surveyor: Amy Keller Specialist At this PSR survey, V Home was found in concern Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSC new section of the but Court, Timm's Trail and contents and contents and contents and court, Timm's Trail and contents and content	t (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the ment of Health in FR 483.70(a). 4 274 A014 1660 y, Life Safety Code Gernon Manor Children's compliance with ticipation in 2 CFR Subpart 483.70(a), and the 2000 edition of the con Association (NFPA) 101, C) and 410 IAC 16.2. The ilding consisting of Kalor and Cherry Blossom dining with Chapter 19, Existing	{K (000}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	PLE CONSTRUCTION G 01, 03		(X3) DATE SURVEY COMPLETED	
		155810	B. WING			R	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 1955 S VERNON ST WABASH, IN 46992	DDE	09/12/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{K 000}	This original section of determined to be of T was sprinklered. A set was of Type V (111) of sprinklered. The facili with smoke detection open to the corridors, detectors were provid The facility has a cap census of 81 at the till All areas where resid were sprinklered. A cowas used for the store was not sprinklered.	of this one story facility was Type II (111) construction and ervice hall and the 300 hall construction and was lity has a fire alarm system in corridors and spaces. Hard wired smoke led in the resident rooms. acity of 119 and had a me of this survey. The survey access detached storage building age of nursing supplies and a specific safety Code.	{K 0				